

MEDICAL STATEMENT Participant Record

(Confidential Information)

Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered by DRESSEL DIVERS CLUB INTERNATIONAL (also legally known as MANTA DIVERS S.A. in the Dominican Republic, and/or BLUE TANG DIVERS, S.R.L. also in the Dominican Republic, and/or CLUB DE BUCEO PLAYA S.A. DE C.V. in Mexico, and/or ACUATICA MAYA S.A. DE C.V. also in Mexico, and/or ACUATICA LITIBUS de RL DE C.V. also in Mexico, and/or SPORTS & DIVER CLUB LTD. in Jamaica).

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba training program.

If you are a minor, you must have this Statement signed by a parent or guardian. Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When established safety procedures are not followed, however, there are increased risks.

Divers Medical Questionnaire To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

1. I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box A	<input type="checkbox"/> No
2. I am over 45 years of age.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box B	<input type="checkbox"/> No
3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR, I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	<input type="checkbox"/> Yes <input type="checkbox"/> * Go to Box *	<input type="checkbox"/> No
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box C	<input type="checkbox"/> No
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	<input type="checkbox"/> Yes <input type="checkbox"/> * Go to Box *	<input type="checkbox"/> No
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box D	<input type="checkbox"/> No
7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box E	<input type="checkbox"/> No
8. I have had back problems, hernia, ulcers, or diabetes.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box F	<input type="checkbox"/> No
9. I have had stomach or intestine problems, including recent diarrhea.	<input type="checkbox"/> Yes <input type="checkbox"/> Go to Box G	<input type="checkbox"/> No
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine (Lariam)).	<input type="checkbox"/> Yes <input type="checkbox"/> * Go to Box *	<input type="checkbox"/> No

*For all other questions answered YES you will be given a supplemental form to complete.

The information I have provided about my medical history is accurate to the best of my knowledge.

I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature

/ / Date (Day / Month / Year)

Signature of Parent or Guardian

/ / Date (Day / Month / Year)

Participant Signature

Date (Day/Month/Year)

Signature of Parent/Guardian (where applicable)

Date (Day/Month/Year)



Participant Name**Birthdate**

(Print)

Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

BOX A – I HAVE/HAVE HAD:			
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.		<input type="checkbox"/> *	No <input type="checkbox"/>
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.		<input type="checkbox"/> *	No <input type="checkbox"/>
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.		<input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.		<input type="checkbox"/> *	No <input type="checkbox"/>
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX B – I AM OVER 45 YEARS OF AGE AND:			
I currently smoke or inhale nicotine by other means.		<input type="checkbox"/> *	No <input type="checkbox"/>
I have a high cholesterol level.		<input type="checkbox"/> *	No <input type="checkbox"/>
I have high blood pressure.		<input type="checkbox"/> *	No <input type="checkbox"/>
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX C – I HAVE/HAVE HAD:			
Sinus surgery within the last 6 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
Ear disease or ear surgery, hearing loss, or problems with balance.		<input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent sinusitis within the past 12 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
Eye surgery within the past 3 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX D – I HAVE/HAVE HAD:			
Head injury with loss of consciousness within the past 5 years.		<input type="checkbox"/> *	No <input type="checkbox"/>
Persistent neurologic injury or disease.		<input type="checkbox"/> *	No <input type="checkbox"/>
Recurring migraine headaches within the past 12 months, or take medications to prevent them.		<input type="checkbox"/> *	No <input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.		<input type="checkbox"/> *	No <input type="checkbox"/>
Epilepsy, seizures, or convulsions, OR take medications to prevent them.		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX E – I HAVE/HAVE HAD:			
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.		<input type="checkbox"/> *	No <input type="checkbox"/>
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.		<input type="checkbox"/> *	No <input type="checkbox"/>
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.		<input type="checkbox"/> *	No <input type="checkbox"/>
An addiction to drugs or alcohol requiring treatment within the last 5 years.		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX F – I HAVE/HAVE HAD:			
Recurrent back problems in the last 6 months that limit my everyday activity.		<input type="checkbox"/> *	No <input type="checkbox"/>
Back or spinal surgery within the last 12 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
An uncorrected hernia that limits my physical abilities.		<input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
BOX G – I HAVE HAD:			
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.		<input type="checkbox"/> *	No <input type="checkbox"/>
Dehydration requiring medical intervention within the last 7 days.		<input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.		<input type="checkbox"/> *	No <input type="checkbox"/>
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).		<input type="checkbox"/> *	No <input type="checkbox"/>
Active or uncontrolled ulcerative colitis or Crohn's disease.		<input type="checkbox"/> *	No <input type="checkbox"/>
Bariatric surgery within the last 12 months.		<input type="checkbox"/> *	No <input type="checkbox"/>

Diver Medical | Medical Examiner's Evaluation Form

Participant Name

(Print)

Birthdate

Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

Signature of certified medical doctor or other legally certified medical provider

Date (dd/mm/yyyy)

Medical Examiner's Name

(Print)

Clinical Degrees/Credentials

Clinic/Hospital

Address

Phone

Email

Physician/Clinic Stamp (optional)

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:

The Undersea & Hyperbaric Medical Society

DAN (US)

DAN Europe

Hyperbaric Medicine Division, University of California, San Diego